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ETHICS AND THE MORAL CENTER OF THE MEDICAL ENTERPRISE*

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MEDICINE is at heart a moral enterprise. All its efforts converge ultimately on decisions and actions which are presumed to be good for some person in need of help and healing.

This fact has been acknowledged explicitly for two millennia in the professional moral codes of eastern and western medicine.[1,2] Whether or not they subscribe to these codes, all physicians implicitly assume an obligation to respect certain normative moral guidelines in the care of their patients.

What has not been so clear until very recently—and what puzzles many physicians today—is that medicine must also be an *ethical* enterprise. That is to say, the physician's actions must have some rational justification beyond simple conformity to one or another ancient or modern professional

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code, however admirable. It is now essential, I submit, that ethics as a formal discipline be recognized to be as integral to the practice of responsible medicine as the basic clinical sciences.

I hope to demonstrate this thesis and its implications for education and practice. As the first speaker I hope to provide a propaedeutic for the more specific comments by my colleagues during the program. Much of what they say will rest on assumptions about what ethics is, why it is important in medical education today, and why it should be taught according to certain canons.

There is no professional ethicist on this program, and I do not presume to fill that role. Although I may say some things in the ethicist's domain, I do so not as a pseudoethicist, but as a physician reflecting on ethics, medicine, and education, and speaking primarily to physicians.

With these caveats, I shall address the following questions: What do we mean by ethics and ethical discourse? Why has ethics become so essential to the medical enterprise today? How, for what purposes, and by whom should it be taught? What central philosophical issues are presupposed in any ethics of medicine?

Ethics and the Problem of Morality

I asserted at the outset that medicine is at heart a moral enterprise. What does this mean, and why did I add the additional requirement that it should also be ethical?

Medicine is intrinsically a moral activity because all of its functions converge upon one end, making a decision for a particular person who presents himself in need, as a patient, someone bearing distress or disease. Everything the physician does, all his skill and knowledge, must focus on a choice of which of the many things he might do he should do for this patient.[3] What is the right decision, the one which is good for this patient, not patients in general, not what is good for the physician, the science of medicine, or even for society as a whole.

The moment we introduce the words right with respect to an action and good with respect to an end we introduce morality, which I define as any system of strongly held beliefs and values against which behavior is judged. Behavior in accord with such values is considered to be moral, behavior contrary to them is immoral. Every aggregation of humans united for some common end—a society, institution, or profession—has some set of values it considers prescriptive and inviolate. Some of these beliefs are

trivial and confined to arbitrary matters of choice or taste; others are held as right for all men because they somehow reflect what it means to be human and to enter relations with other humans.

The Hippocratic Oath and Corpus and its successors and analogues codify moral behavior for physicians. They imply that values enter into medical decisions and that the self-interest of the physician and the demands of his art are to be shaped by the nature of the special human relation between the healer and the person seeking to be healed. These values define guidelines for moral or approved decisions and actions in that relation.

Medicine is, therefore, a moral enterprise in two senses: first, in that its central and most characteristic function focuses on a right decision which is good for a patient; second, it explicitly codifies the values which should guide the good physician's decisions. But these considerations do not automatically make medicine an ethical enterprise, even though these codes are often called codes of ethics, and a physician who follows them is considered an ethical physician. To be ethical is not synonymous with following a code of moral principles.

Ethics comes into existence, properly speaking, when morality itself becomes problematic, when the validity of beliefs about what is right and good comes into question or when a conflict between opposing moral systems or obligations must be resolved. Morality takes its values and beliefs for granted as presuppositions that apply to all men. Ethics emerged as a formal discipline when the sophists and Socrates first began to question Greek presuppositions about the right and the good in political and social life. Among them, morality for the first time became explicitly problematic and the history of ethics since then has been an attempt to examine the presuppositions about what is right and good and what should be normative for human actions.

Ethics, then, is a formal intellectual discipline, a branch of philosophy that systematically examines the rectitude of human actions. Classical ethics was normative in that it attempted to arrive at generalizable principles of right conduct together with their rational justifications. Modern ethics has concentrated on the meanings, usages, and logic of moral terms and statements, attempting more to clarify moral discourse than to make general rules about conduct. It is thus metaethical in its bias. Both activities, the normative and the metaethical, are, however, subject to disciplined thought which examines moral principles and statements for co-

gency, applicability, consistency, and the validity of the assumptions from which they derive.

If medicine is to become an ethical enterprise in the sense in which ethics has just been defined, then it must subject its traditional and current morality to systematic and critical examination. It must not only recognize the central role of values in the decisions it takes but must be prepared to justify the values it chooses as the basis for those decisions. Ethics, then, must become an integral element in the education and the practice of the contemporary physician. Indeed, it has become indispensable if the profession is to fulfill its social responsibilities today and in the forseeable future.

The Indispensability of Ethics for Modern Medicine

While most physicians recognize the essentially moral nature of their enterprise, many are confused by, and even resist its conversion to an ethical enterprise. Why, they ask, is a common sense interpretation of the Hippocratic Oath and its recent modifications no longer adequate? While acknowledging the importance of the newer moral problems created by medical progress, it seems to them that all we require is amplification of traditional professional codes. What can ethicists, lawyers, and philosophers— inexperienced in the intricacies of clinical medicine—add, except obfuscation?

Moreover, many physicians hold to the common view that morals and values are not matters to be settled by rational discourse. A physician's values are learned "at his mother's knee" or in church. Medical school comes too late to try to teach what is right and good. Moral values, whether we hold them to be relative or absolute, cannot be settled by rational discourse and, anyway, we must follow our consciences, not theorizing ethicists.

These attitudes are by no means confined to physicians, but they are heightened by the positivist bias of modern medical education. Ethical discourse, and, even more specifically, normative ethics are among those intellectual ventures that cannot be resolved by empirical or experimental method. They seem futile exercises, doomed to end in frustration at best and unnecessary enmities at worst. Medical students would do better to expend their energies in understanding disease mechanisms and solving practical problems.

These disinclinations of many physicians to ethical discourse are unfortunately reinforced by the openly critical, oversimplified, and adversarial attitudes of some ethicists. Those who take the trouble to teach and

function at the bedside emerge with a deepened respect for the complexities of the physician's moral choices. But ethicists without these insights have generated an unfortunate backlash which hinders precisely the critical engagement of the moral issues in clinical decisions which contemporary medicine needs.

Many physicians may hold to the ethical theory that morals are created by social attitudes. What is right and good is therefore determined and defined differently in different societies. It is useless, they hold, to argue about generalizable principles of right conduct. The same can be said by those who equate the good with whatever makes one feel comfortable. Any attempt at a rational consideration of such a relativistic subject as morals is certain to lead only to clashes of irreconciliable opinions in which no one is convinced.

Against all these opinions antithetical to ethics as a useful discipline there are compelling reasons to justify training physicians in ethics. Indeed, I would hold that some familiarity with the formal discipline is as important as familiarity with the principles of the basic sciences and the pathophysiology of disease. Some of the reasons for this assertion follow.

First, simple reliance on professional moral codes is inadequate to cope with the complex obligations imposed on the modern physician. Professional codes are of necessity couched in general terms, terms often vaguely defined and open to serious differences of interpretation in their application to specific cases. Commendable as they may be, codes may also contradict each other or create conflicts of obligations not resolvable in the codes themselves. The older codes, moreover, developed without the challenges to values posed by recent technological advances.

These limitations are illustrated by such examples as the differing nuances in the provisions assuring confidentiality in the Hippocratic Oath, the International Codes, and the codes of the American or British Medical Associations. We can also cite the absence of any recognition of social obligations in the Oath of Hippocrates, their variable mention in the American revisions, and their overriding importance in the Soviet physicians' code. I have elsewhere pointed out the silence of the Hippocratic ethic on a variety of problems of urgent importance to modern medicine.[4]

Beyond these difficulties is another, even more fundamentally important for our times, that is, that professional codes, ancient and modern, have customarily been drawn up by the profession. While benevolent in intention, these codes enjoin the physician to do what he deems best for the

patient. But no mention is made of the patient's participation in that determination. The physician is assumed to be the patient's moral agent, and no notice is taken of the possibility of a conflict between the physician's and the patient's value systems.

Such a paternalistic construing of the physician-patient relation is increasingly untenable and even immoral. For many urgent reasons patients now wish to exercise their own moral agency.[5] They are better educated and can understand the alternatives in medical decisions better than ever before, and legal opinions in democratic societies assure the individual of the right to accept or deny treatment. Moreover, the capabilities of modern medicine now extend to preventing, prolonging, or discontinuing life at will as well as modifying generation, genetics, and behavior— offering possibilities of intrusion into man's most personal and intimate existence. Even in the more mundane medical encounters, striking the balance of efficacy against harm, expense, and discomfort requires the most careful assessment of what is worthwhile or of value to the patient.

If moral paternalism were ever justified, even in simpler times, it had to be on the basis of some commonly shared set of values. But if there is a moral characteristic of our times it is pluralism—not just between societies, as has always been the case, but within societies and even between individuals in the same family. Each physician represents only one set of the divergent views we hold today about the value of life, health, or happiness.

In almost every medical encounter these days there is the possibility of conflict between the intersecting values of physician and patient. Each may differ about what is right and most in the patient's interests, even when there is relative certitude about the clinical facts. Neither the physician's nor the patient's moral beliefs can justly be given automatic precedence. The codified morality of the profession no longer suffices to resolve these dilemmas.

The physician's beliefs are particularly susceptible to critical examination because illness makes the patient so vulnerable. The physician possesses the advantage of knowledge and power in the relation. The physician thus has the greater responsibility for assuring that the moral center of his acts as physician—choosing what is good for another human being—is morally managed. Ethics can provide the tools for recognition of the ethical issues, the values which underlie our opinions about them, and conditions for a just and moral management of the decision-making process.

None of this contravenes the heavy emphasis placed by so eminent a clinician as Richard Clarke Cabot on the moral imperative of competence in differential diagnosis and relating the patho- physiological disturbances to the needs of the particular patient. Chester Burns, in a recent study, asserts that Cabot's emphasis on the importance of clinicopathological correlations constituted an abnegation of traditional professional ethics.[6] This seems a rather extreme view and a little out of focus. It certainly does not vitiate the assertion that ethics is as intrinsic to the physician's clinical functions as are the basic sciences and clinical methodologies.

On the view I am propounding, accuracy of clinical diagnosis and skill in differential diagnosis in the Cabot tradition are still essential to moral clinical decision-making. I have argued that these skills are moral imperatives as well.[7] But they are anterior to and not synonymous with the moral center of medicine, which is located at a precise point, recommending what should and ought to be done. No matter how accurate the diagnosis and how appropriate the therapy, most clinical situations involve choices which patient and physician may regard of different worth.

Clinical competence is necessary to moral decision-making but not sufficient for it. It is obviously essential to diagnose disseminated cancer of the breast accurately but this does not dictate whether treatment should be instituted and what kind. It is indispensable to the decision to discontinue life-support measures in a patient with irreversible brain damage that the diagnosis and prognosis be as precise as possible. It is one thing to discuss the need for blood transfusion for a Jehovah's Witness or abortion for a Catholic, but another thing to expect patients to accept the treatment or to manipulate their consent.

Clinical competence is in no way compromised by a knowledge of ethics. Ethics is only enhanced when the clinical issues it examines are defined as verifiably, accurately, and in as much detail as possible.

For What Purpose, By What Method, and By Whom Should Medical Ethics Be Taught

If ethics is to be an integral part of medical education, its objectives and methodology must be carefully delineated. The medical curriculum is already overcrowded dangerously, and further additions will not survive unless congruent to the specific needs of medical students and the ways they learn. The same applies to the teaching of ethics in postgraduate and continuing education.

In 1976 Veatch and Sollitto found that a high percentage of American medical schools teach ethics in some form. Most programs were not formally organized; few professionally trained ethicists were involved, and few courses were required.[8] Nonetheless, this indicates rather a remarkable resurgence of interest considering that even a few years ago the teaching of medical ethics was moribund, limited largely to sectarian schools, and taught by an obscure faculty auxiliary whose desultory classes were poorly attended.

The most recent survey conducted by our own Institute of Human Values in Medicine shows a significant increase even during the last two years in the number of formal programs in human values and in the participation of bona fide ethicists or philosophers.[9] Many are, in fact, part of broader efforts to re-expose medical and other health-profession students to the humanities as part of their professional education. We know of some 81 of the 115 medical schools surveyed that have a human-values teaching program. An unknown number of schools of nursing and allied-health sciences also have programs.

Our institute has evaluated or consulted with some 50 of these programs through on-site visits.[10,11] I would like to draw on our observations during these visits to define what seem to me to be the most essential features of a successful program.

To begin with, the objective of teaching ethics in medicine is a limited one. It is *not* to make physicians ethicists or to make ethicists unnecessary in medical education. Instead, the teaching should alert students to the central position of moral and value issues in medical decision-making, acquaint them with the reasoning used in ethical discourse, help to uncover the assumptions upon which moral judgments are based, and enable students better to understand their own moral value systems. In addition, some comprehension of ethical theories—historical as well as contemporary—and the modes of reasoning used to justify moral choices is requisite.

Teaching ethics to medical students cannot provide sure-fire formulae to resolve moral dilemmas in clinical practice or substitute for a formal college course. The physician needs the same acquaintance with the concepts, methods, and language of ethics that he is expected to have with the sciences. Ethics becomes, then, a tool by which he can form, explicate, and justify his own moral choices, and by which he can evaluate the choices others make. Recognizing his own definitions of right and good,

the physician can better decide where he can and where he cannot compromise with the divergent views of patients, institutions, society, or government. In a word, the purpose of teaching ethics is to make the physician's moral life in his professional life an examined one—not an automatic or autocratic posture to impose on others.

The second point is that these skills and techniques must be taught around the matter of medicine and not abstractly or didactically. Medical students are unreceptive to the format of college teaching, and interest is best engaged by a concrete clinical problem and developing principles from some real dilemma, not the other way around. This is the most difficult lesson for ethicists, philosophers, and other teachers of the humanities in a medical school. Those who fail almost always are unable to adapt to case and problem-oriented modes of teaching.

The more successful programs, judging by student acceptance and faculty impact, introduce ethical principles in the context of common and preferably current moral dilemmas such as abortion, prolongation of life, confidentiality, the natural death act, informed consent, allocation of scarce resources, and the like. Underlying ethical issues, their theoretical frameworks are identified and arguments for opposing views are critically examined. Ethical grand rounds patterned closely after the usual medical grand rounds have been particularly well received in such institutions as the University of California at Los Angeles, University of Virginia, Yale University, and the University of Tennessee.[12]

Teaching can be multidisciplinary, provided adequate preparation of all participants well in advance of the session is assured. Interdisciplinary teaching is always hazardous, even more so the teaching of ethics. It is essential that the disciplines included are in fact related to the problem the case illustrates. Simply to display the relation of disciplines rather than the way they are needed to understand or to resolve a problem is lethal.

Ethics should be taught at several levels, and it is unrealistic to expect that all students will be interested in all levels. To be sure, all students should have an opportunity to participate through discussion, reading, and listening in case and problem-oriented sessions. Smaller numbers of students will develop a more serious engagement with ethics as a discipline, and their interests are best accommodated by electives, a research paper or thesis, or even by a year of dropout graduate study in ethics.

Far and away the most effective impression of the value of ethics will come if teaching can be located at the heart of the physicians' activity, at

the bedside at the moment the actual decision is being made. Here questions of rightness and oughtness are particularized in the existential situation of a patient. Here the intersection of the physician's and patient's values and the conflicts of obligations all physicians face will impress themselves with a force unattainable in the classroom.[13]

To be effective, bedside teaching of ethics requires the cooperation of the clinician and ethicist. Neither is alone sufficient. In the moment of clinical truth, even as we answer the question, "What shall I do?" ethics must remain a rigorous intellectual effort. The clinician must ground the problem in reality, the ethicist must identify and dissect free the ethical issues. The clinician must overcome impatience with the careful cogitations ethics demands, and the ethicist must avoid being intimidated by the complexity and urgency of the setting. Of all people, the ethicist must avoid moralizing or condescending attitudes.[14]

A certain constructive tension between ethicist and clinician is to be encouraged. Each needs the other's special viewpoint if moral problems are not to dissolve in a syrup of reconciliation as an end in itself. Ethicists and clinicians clearly must share something of each other's language and method while preserving the identity and autonomy of their own disciplines. There is little room for either the physician as amateur ethicist or the ethicist as amateur clinician. Nothing will more effectively dissuade the student from the utility of ethics in medicine than pretentious shallowness.

The range of problems taught under the rubric of medical ethics has been very broad and has included biomedical ethics, e.g., specific ethical problems such as abortion, experimentation, transplantation, genetic counselling, and the like; professional medical ethics, e.g., the ethical foundations of the physician-patient relation; and social medical ethics, e.g., the impact on society of individual or corporate medical acts, and the collective obligations of members of a team or institution when acting corporately.

Our institute[15] has found that in a significant number of medical schools ethics is taught as part of a broader program in human values, usually with other branches of the humanities. Varying combinations of history, philosophy, literature, and theology as well as the social sciences and legal medicine are offered. Without analyzing these programs, it suffices to say that medical ethics can profit by being part of a broader consideration of human values. This conjunction of ethics with the other humanistic studies

should clarify the connections as well as the distinctions between ethics and morals.

The teaching of ethics in medical schools today seems well launched, and is expanding at an unprecendented rate. But ethics must also be an integral part of postgraduate and continuing education, subjects which will be covered by other speakers. I need only add that the same pedagogic methods which have proved successful in undergraduate medical programs are proving to be equally so at the other levels of medical education.

Some Philosophical Questions at the Foundations of Ethics

I have thus far emphasized the practical utility and importance of ethics for medicine. But the three major domains of medical ethics—the biomedical, professional, and social—rest upon certain philosophical foundations. These form our opinions on each of the specific medical-moral issues of our day. The ethical examination of medicine uncovers the importance of the philosophical foundations of all ethical discourse. Ultimately, the vast differences in these foundations must be recognized. I will, therefore, outline a few critical questions in philosophical ethics.

One very serious problem concerns the possibility of constructing a universally acceptable professional moral code in the pluralistic moral climate of our times. Is such a code even desirable? We must remember that the Hippocratic Oath, which so many have taken as typical of the moral values of the Greek physician, has been demonstrated as quite nonrepresentative. Ludwig Edelstein demonstrated that the Oath represented Pythagorean views and that many of its precepts were foreign to the Greek ethos. Many of the proscriptions in the Oath—such as those against abortion, euthanasia, and surgery—were violated by Greek physicians who held to philosophies other than the Pythagorean.[16]

When the oath was Christianized during the middle ages it may have, paradoxically, been more representative of the dominant value system than it was in Greek times. Christianity and Judaism were more influential in European culture than Pythagoreanism in Greece, and they shared common views on the sanctity of life and the meaning of illness.[17]

Today, the problem of a universally acceptable professional code is vastly complicated for want of any generally held ethical theory. The influence of Judeo-Christian moral values is no longer prevalent as it once was in western society. Can ethical relativists and objectivists, utilitarians and consequentialists, and Kantian deontologists or natural law adherents

find common ethical ground? We need only look at the divergent views each takes on the most common moral dilemmas of clinical medicine to appreciate how far we are from any code acceptable to all.

Must we abandon the effort in consequence, and with it the idea of a morally united profession so long based in the Hippocratic Oath and Corpus? What will be the impact of that abandonment on a profession already so seriously divided that physicians can hardly communicate? It seems to our severest critics that the common bond is not a common moral commitment but a defense of social and economic privilege against public and governmental intrusion.

Is the answer, as some suppose, to be found in an eclectic amalgamation of opposing ethical theories, adding a little Kantian deontology to Bentham and Mills' utilitarianism, and spicing both with natural law? The different philosophical views of what is right and good are logically and metaphysically incommensurable. Indeed, the more possiblities technology offers us to modify human existence, the sharper these differences become; new technology always poses the question of purpose which in turn uncovers fundamental divergencies among the philosophical foundations of ethics.

I think the best possibility to reconstruct a common professional code lies in the development of a common philosophy of the physician-patient relation. Some common understanding seems achievable in what the relation means and the obligations it implies for both physician and patient. These obligations could become the commonly accepted guide for all physicians—indeed for all health workers. This is the hope of such commendable efforts at constructing a sound moral basis for the physician-patient encounter as Robert Veatch's contractual[18] and Paul Ramsey's covenant theories.[19]

I have delineated my own efforts in the construction of such a philosophy elsewhere.[20] What I have proposed is to found professional medical ethics in the *fact* of illness and the *act* of *profession*. I would suggest that the *fact* of illness wounds the humanity of the person who is ill and deprives him of some of the freedoms most fundamental to being human—freedom to move about as one wishes, freedom to make one's own decisions, freedom from the power of others, and freedom to construct one's own self-image. Illness, pain, disability, and disease rob us of these freedoms and create an essential inequality between patient and physicia... I submit that the preponderance of obligations rests with the healer who voluntarily declares himself at the disposal of the person in

need. That voluntary declaration raises certain expectations, not only that the disease will be cured, but that the damage to the patient's humanity, the vulnerability of being ill, will not be ignored in the curing.

A new relation must evolve between patient and physician to recognize that the clinical decision—the heart of medicine—the choice of what is to be done, cannot be the exclusive privilege of one or the other. That decision must arise somehow, in the ground between someone in need, the patient, and someone, the healer, who professes to alleviate that need. Manifestly, on this view the long-held notion of the benign but authoritarian or paternalistic physician deciding what is best for his patient needs drastic revision. A more adult relation based on a mutual respect for each other's value system is required. This requires full disclosure of what is to be done and an assessment of alternatives of what is worthwhile in the patient's estimation. Such an adult relation calls also for a frank appraisal of the degree of congruence or lack of it in patient and physician value systems. Each party must be able to know when he reaches a point at which compromise would violate conscience.

The objection is often raised that asking the patient to participate in clinical decisions may be psychologically or even physically damaging. Illness induces a state of dependence in many patients, and some patients seek rather than reject the physician's paternalism. We lose a powerful psychological tool; we place unwelcome burdens on patients and families; and we default on our responsibilities if we do not make the decision for the patient. Indeed, this was the substance of the Hippocratic injunction against informing patients of their condition found in the *Decorum*.[21]

There is no doubt that patients vary in their desire for disclosure and for the fullness of consent to what the doctor recommends. But an increasing number of patients emphatically reject the dependent role. Moreover, all the weight of legal opinion has been progressively in favor of full disclosure and patient participation. This is evidenced also in the patients' bills of rights now appearing in significant numbers.

It is one thing for the physician to assume that he has the authority to decide what is good for a patient on his own, and quite another thing to assume this responsibility if the patient or family ask him to do so because they feel incapable of understanding or choosing the alternatives. It is certainly not improper for the physician to respond to such a request. But under these circumstances he is responding to a mandate given to him by the patient or family; he is not automatically assuming that mandate. This

is a distinction which traditional medical moral codes have not made clearly, or at all.

A philosophically grounded source for professional medical ethics will, at least, define the obligations of the physician as physician, irrespective of what specific bioethical dilemma he may face. While physicians and patients may differ on what they think is right and good, for example, whether abortion or "mercy killing" is permissible, they should be agreed on a moral way to deal with the conflicts and the tragic choices. Medicine abounds in choices between good things in which each good is equally potent and conflict irresolvable and unavoidable. While there is much concern today about the morality of what physicians do, there is even more anxiety about the way they handle or fail to handle value differences and moral conflicts between themselves and their patients. Physicians and other health professionals can no longer assume a moral agency to which society no longer entitles them.

We must not neglect the equally important consideration of the patient's obligations to the physician. In any really mature and adequate morality of the physician-patient relation, the patient too has obligations: to cooperate once a decision is made, to tell the truth, to respect promises, to respect the values of the physicians; and to educate himself sufficiently to be able to deal with the information he receives. The matter of the patient's moral obligations is just beginning to be explored. I have placed more emphasis, however, on the physician's obligations because the patient is more vulnerable and the greater power rests with the physician.

The philosophical groundwork for a morally acceptable physician-patient relation is further complicated today because physicians rarely function in isolation, and, explicitly or implicitly, are members of a team in which other health professionals—nurses, pharmacists, allied health workers—share in the care of most patients. Unfortunately, the philosophical groundwork for a theory of collective responsibility is still very much in its incipient stages. What are the mutual responsibilities of individual team members to each other, to the physician, and to the patient in making and carrying out collective decisions? Are the obligations distributive—every professional responsible for himself—or nondistributive, somehow shared corporately? What are the moral implications of a patient's relation with a group or an institution?

Any generally acceptable professional moral code must include these new dimensions of the relation of the patient and those who attempt to heal

him. It seems obvious that such a code must be developed cooperatively among the several professions. Indeed, what must emerge is a common code for the health professions rather than, as is now the case, a series of codes.

This will be very vexatious indeed for medicine, which considers itself the senior profession, and for the other professions, which are striving for their own identities. Despite these realities, the health professions will only lose further moral credibility if they permit professional prerogatives to override the need for a more sensitive statement of their common moral obligation as professed healers.

These questions at the foundations of ethics bring us closer to even more fundamental problems that we can only mention. What we think is right and good depends, after all, on what we think man is, what his existence is for, what medicine is, and what its role is in human existence. The metaphysics of medicine and of man are the well-springs from which flow our theories of ethics as well as the criteria we use to judge the rectitude of human acts.

In perusing ethical issues critically and dialectically, the physician also confronts the timeless questions about human nature and existence. The effort will make him a better person and a better physician. The place of ethics in medical education ultimately needs no more convincing justification than that.

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